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Public Health Committee
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Comments from the American Cancer Society Cancer Action Network on **S.B. No. 290 - AN ACT CONCERNING THE SALE AND PURCHASE OF TOBACCO PRODUCTS, ELECTRONIC NICOTINE DELIVERY SYSTEMS AND VAPOR PRODUCTS AND SIGNAGE CONCERNING THE USE OF SUCH PRODUCTS AND SYSTEMS.**

Despite significant progress since the first Surgeon General's report, issued 50 years ago, tobacco related diseases are the single most preventable cause of death in our society, yet according to DPH statistics, tobacco use continues to kill more people in Connecticut each year than alcohol, AIDS, car crashes, illegal drugs, accidents, murders and suicides *combined*.

Nearly 90 percent of smokers have starting smoking by age 18 and 99 percent have smoked their first cigarette by age 26. In Connecticut, 4,300 kids under 18 will try tobacco for the first time this year and many of them will move on to using multiple tobacco products. As adolescents' brains are more susceptible to the effects of nicotine and nicotine addiction, powerful interventions are needed to keep youth from life-long addictions to these deadly products.

SB 290 seeks to increase the minimum tobacco purchasing age in Connecticut from 18 to 21. This is a promising intervention worthy of discussion. Raising the minimum legal age of sale for tobacco can be implemented as part of a comprehensive tobacco control strategy that includes proven ways to reduce death and suffering from tobacco-related illnesses.

According to a March 2015 Institute of Medicine report- *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*[i], raising the national minimum legal age to 21 is predicted to reduce smoking prevalence by about 12 percent and smoking-related deaths by nearly 10 percent for future generations.

The report authors predicted that raising the minimum age of sale for tobacco products, including electronic cigarettes, will prevent tobacco use, reduce suffering and death from tobacco-related diseases and save lives among the next generation of Americans.

It is important to note, however, this IOM report makes predictions about the effectiveness of increasing the minimum age of sale for tobacco products based on

projection models. It takes more than just changing 18 to 21 in existing statutes for the desired health benefits to be reached.

There is no direct evidence yet to support the effectiveness of increasing the minimum legal sale age for tobacco products as a stand-alone strategy for reducing youth and young adult tobacco use and initiation. This lack of evidence is largely due to the fact that the minimum tobacco sale age has been increased to age 21 only in Hawaii, effective January 1, 2016—two months ago-- and in a number of municipalities in several states.

Additionally, laws prohibiting sales to minors have historically not been effective stand-alone measures. Compliance with the law should be largely the responsibility of the retailer, and penalties for violations should not fall solely on the youth attempting to purchase tobacco. The focus should be on increasing the minimum age of sale, not the minimum age of purchase.

Public education campaigns and training and technical assistance for retailers must be provided following implementation to increase public awareness and enforcement of the new law.

More research on how effective raising the minimum sale age is in reducing tobacco use is critical and we strongly recommend the bill include a commitment to fully monitor analyze and evaluate, through a nonprofit or government entity with expertise in evaluation of tobacco control policies, the impact this policy would have to add to the body of research supporting this intervention.

Most of the existing statutes amended by this bill have been in place and largely unaltered for over 20 years. While reflective of the best thinking and best practices of the time, two decades of additional evaluation and development of more appropriate interventions suggest this is an opportune time to update our existing statutes to more adequately ensure people are protected from the dangers of tobacco use.

The evidence shows state and local governments can reduce tobacco use, save lives and save money by implementing three proven solutions to the problem: 1) Implementing smoke-free laws 2) Regular and significant increases in tobacco taxes and 3) Fully funding evidence based tobacco prevention and cessation programs. Separately each approach can help, but putting into place all three of these strategies will maximize the benefits to the states.

A 2013 study published in the *American Journal of Public Health* found that between 2002 and 2008, each of these measures separately contributed to declines in youth smoking and together they reduced the number of youth smokers by about 220,000. The study also found that states could achieve far greater gains if they more fully implemented these proven strategies[ii].

2015 CDC Statistics indicate 4,900 people will die in Connecticut this year while 4,300 people--90% of whom are under 18-- will try tobacco for the first time[iii]. Statistically

speaking, therefore, one or two people in Connecticut will have died from causes related to tobacco use during the course of this hearing today. Adding to the tragedy, someone in Connecticut will have tried tobacco for the first time during course of this hearing as well.

Connecticut receives $487 million annually between the MSA funds and tobacco tax revenue. Over the years, however, less than 1% of the cumulative total has been spent in support of smoking cessation services. In 2013 we spent $6 million on TUC, for 2014 and 2015 that number was cut in half. However for FY '16 and now FY '17, that number is zero. *Our children are worth more than zero*.

It gets worse. Since it's inception in 2000, the Tobacco and Health Trust fund has been raided or had funds redirected 67 times. Of the total deposits into the THTF since 2000, only $29.7 million will have been spent on tobacco control while $195.7 million has been redirected to non –tobacco related programs, including $134 million redirected directly into the General Fund[iv]. Three times now in the last 8 years, the state spent $0 on tobacco control and once again this budget proposes we spend $0.

The CDC recommends $32 million be spent on tobacco control programs in Connecticut *per year*. To put it starkly, we have dedicated a cumulative total of $29.7 million for tobacco control during those 16 years-- *$2.3 million less than the CDC recommends we spend annually*. While the state has continually underfunded programs with proven results and now has eliminated funding them altogether, *Connecticut incurs $2.03 billion in annual health care costs.*

We can, should and need to do more. We know what can be done, what has a demonstrably proven level of success and at what cost and with a reasonable expectation on return of investment.

The 2014 Surgeon General's report found, "States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased.[v]" The report concluded that long-term investment is critical: "Experience also shows that the longer the states invest in comprehensive tobacco control programs, the greater and faster the impact."

States that have funded tobacco control have indeed seen results:

- Washington State saw a 5-1 savings with their program between 2000-2009 and cut adult smoking by a third and youth smoking in half[vi].
- Florida, which has a constitutional amendment that provides $66 million per year, has seen their adult smoking rate plummet from 21.1% in 2007 to 16.8% in 2014 and their youth smoking rate drop to 6.9% in 2015 from a high of 10.5% in 2006[vii].
- In California, lung cancer rates declined by a third between 1988 and 2011[viii].

- Alaska, one of only two states to fully fund according to the CDC recommendations, has cut its high school smoking rate by 70% since 1995[ix].
- Maine reduced its youth smoking rates by two thirds between 1997-2013[x].

70% of Connecticut's smokers indicate they want to quit while 40% attempt to quit each year, however only about 5% are successful. Many fail because, in part, of a lack of access to successful cessation programs. Funding tobacco use prevention and cessation programs that alleviate this burden on our citizens and economy are not only consistent with our shared goal of insuring access to care to those in need, it is also the only fiscally responsible approach we can take.

Research shows that frequent tobacco tax increases, smoke-free workplace laws and fully funded tobacco cessation and prevention programs reduce youth initiation and help tobacco users quit.

Tobacco use remains the leading cause of preventable death in this country. The U.S. Surgeon General estimates that 56,000 Connecticut youth alive today will lose their lives prematurely if we don't do more to reduce current smoking rates[xi]. State policymakers must support proven policy interventions that reduce tobacco use so our children can grow up in a tobacco-free generation.

Thank you for your consideration of our comments.

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[i] http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/TobaccoMinAge/tobacco_minimum_age_report_brief.pdf

[ii] Matthew C. Farrelly, Brett R. Loomis, Beth Han, Joe Gfroerer, Nicole Kuiper, G. Lance Couzens, Shanta Dube, and Ralph S. Caraballo. A Comprehensive Examination of the Influence of State Tobacco Control Programs and Policies on Youth Smoking. American Journal of Public Health: March 2013, Vol. 103, No. 3, pp. 549-555. doi: 10.2105/AJPH.2012.300948

[iii] CDC, *Best Practices for Comprehensive Tobacco Control Programs—2014*, http://www.cdc.gov/tobacco/stateandcommunity/best_practices/.

[iv] Tobacco and Health Trust Fund Annual Report, 2014 - http://www.ct.gov/opm/lib/opm/secretary/tobacco/2014_tobacco_&_health_trust_fund_report.pdf

[v] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[vi] Washington State Department of Health, Tobacco Prevention and Control Program, *Progress Report*, March 2011

[vii] Florida Department of Health. Bureau of Epidemiology, Division of Disease Control and Health Protection. Florida Youth Tobacco Survey, 2015, http://www.floridahealth.gov/statistics-and-data/survey-data/fl-youth- tobacco-survey/_documents/2015-state/index.html

[viii] California Department of Public Health, California Tobacco Control Program, California Tobacco Facts and Figures 2015, Sacramento, CA 2015, https://www.cdph.ca.gov/programs/tobacco/Documents/Resources/Fact%20Sheets/2015FactsFigures-web2.pdf

[ix] Alaska Tobacco Prevention and Control Program Annual report http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/TobaccoARFY13.pdf Alaska Department of Health and Social Services, "2015 Youth Risk Behavior Survey Results," November 2015, http://dhss.alaska.gov/dph/Chronic/Documents/yrbs/2015AKTradHS_YRBS_SummaryTables.pdf.

[x] National Youth Risk Behavior Survey, 1997 and 2013.

[xi] Youth projected to die prematurely: *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General,* 2014.